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# **Autonomy and Caring: Toward a Marxist understanding of nursing work**

## **Introduction**

The aim of this paper is to re-examine nursing work from a Marxist perspective. Marx's theories were developed in the 19<sup>th</sup> century but recent global economic crises that have exposed some of the dangers of capitalism have led many to return to Marx and re-consider his theories (Liedman, 2018). This paper is one part of such a re-consideration.

The way into this examination of nursing work will be via a critique of two connected and highly valued concepts within nursing: autonomy and caring. Professionalisation and its contents, for example the promotion of the concepts of autonomy and caring, exert a strong influence on how the identity and work of professionals is understood—by those outside the profession but perhaps more strongly by its members (Freidson, 1994). This paper is part of a larger on-going project investigating what the thinking of the 'three masters of suspicion', Marx, Freud and Nietzsche, can contribute to a new understanding—a critique—of nursing.

I start by summarising some of the key concepts and arguments in Marx's understanding of society, followed by some objections, then move on to sketch out a broad representation of professions, focussing on United Kingdom (UK) nursing, though nursing in the United States (US) will be referred to for comparison. I then move on to place nursing in its context in the UK National Health Service before offering what is intended to be a Marxist critique of nursing work focussing on the two areas outlined above. I will approach this first by summarising a sociology of the professions that has emerged (mainly) from Marxist-inspired writers and then move on to an analysis of professional nursing work within neoliberal managerialist regimes in the form of an understanding of what has become known as emotional labour.

## Marx as one of the three masters of suspicion

Karl Marx was labelled by Paul Ricoeur as one of the three masters of suspicion, along with philosopher Friedrich Nietzsche and Sigmund Freud, neurologist and founder of psychoanalysis. These three thinkers have shaped the mood of the twentieth century – and beyond. Each of them, working in different fields, according to Ricoeur, ‘sought to unmask, demystify, and expose the real from the apparent’. However, Ricoeur was keen to emphasise that the three were not masters of *scepticism*. This was, he said, because:

All three clear the horizon for a more authentic word, for a new reign of Truth, not only by means of a 'destructive' critique, but by the invention of an art of interpreting. (Ricoeur, 1988 p. 194)

In other words, each, in their own way, unmasked what has been called false consciousness, a false understanding of ourselves, of society and morality with the result that a true understanding becomes revealed. Their approach has been called a ‘distinctively modern style of interpretation that circumvents obvious or self-evident meanings in order to draw out less visible and less flattering truths’ (Felski, 2012). Their ideas have pulled the rug out from under many comforting certainties that have been foundational to Western culture, or parts of it, since the nineteenth century. The highly prized notions of autonomy and caring can perhaps be seen as nursing’s own comforting certainties.

Marx has, to the best of my knowledge, never written about the occupation of nursing, although the link between capitalism and health has been well explored. In this paper I am asking what it might be to develop a Marxist understanding of nursing today and how this approach might help us to make sense of some of the puzzles and contradictions that we see at work in the profession and in writing about the profession today.

## Karl Marx (1818-1883)

Marx was born in Germany and arrived in London in 1849 after being expelled from a number of European countries for his radical views. He worked in

collaboration with fellow German, Friedrich Engels. The starting point for his work is a belief that modern society is divided into two classes of people, those who own and control the structures and means of producing society's goods, the bourgeoisie, and those who own nothing or very little and who are obliged to sell their labour to the first group to survive, the proletariat. It is unclear into which group today's professions should be placed. In the sense that a doctor or nurse sells their labour to an organisation they might be considered members of the proletariat (see later comments about proletarianisation). If they have some control over the services that they sell, for example in terms of private practice, we might consider them petit-bourgeoisie. When they become managers in corporations they could be considered bourgeoisie. While they are not necessarily owners of the means of production, they often help to facilitate its operation. The interests of these two groups—bourgeoisie and proletariat—are clearly different and because of this society is characterised by class conflict.

Marx understood the ownership of the means of production as the most important single factor in the history of human society. He saw history in terms of a number of periods, or epochs. For example, he proposed a period of early communism where people held everything that we might today call property in common. Feudal society, followed, during which wealth and production was based on the land ownership of the aristocracy. It was this system, according to Marx, that was replaced by the beginnings of today's capitalist society. Here technological development, for example Britain's 'industrial revolution' of the 18<sup>th</sup> and 19<sup>th</sup> centuries, allowed the bourgeois class to exploit the efficiencies of factory-based production for its private gain. The only option for the majority of the people is to become wage-labourers, separated or alienated from the products of their work. Marx saw the industrializing West's colonization of great parts of the globe in terms of the ever more efficient exploitation of resources and labour—the beginnings of globalisation. The main relations of production in this epoch are between employers and employees (those who own and use capital and those who exchange their labour power for wages). Marx believed in an 'end of history' when the contradictions of capitalism (that the means of production become

owned by fewer and fewer people for example) would lead to its demise and the final epoch would be characterized by the ownership of the means of production by all, for the benefit of all.

Marx's project was, as is well-known, to change society and bring about the end of history—through a revolution of the proletariat. The first stage of this project is to undertake a thorough critique of capitalist society in order to expose its workings.

Part of that critique concerns an analysis of the operation of power. Those who own the means of production are able to use their wealth to enhance and expand this power. They translate this power primarily into political influence in terms of control over the operation of government. However, they also develop and mobilise ideological power or control over how people think about the nature of the social world and their own place in it. Marx developed the notion of what Italian Marxist philosopher Antonio Gramsci later expanded and termed hegemony (Gramsci, 2016), 'leadership with the consent of the led', to describe this. For example, a political and cultural version of society is promoted by sections of the popular press. This popular press is owned and controlled by a small number of wealthy individuals. The ruling class can establish its hegemony over other classes through the use of force, for example through the police, but also by means of ideology and socialisation via the mass media and the education system. Louis Althusser, writing in 1970, called these forms of control 'Ideological State Apparatuses' (Althusser, 1971). Capitalist ideology attempts to make other forms of organising society literally unthinkable. The concept of false consciousness is a powerful one to explain how the proletariat is drawn in by the ruling class to the values of capitalist society, failing to see, according to Marx and his followers, their true position as members of an exploited and oppressed group.

## Critiques of Marx

Marx developed his theories over 150 years ago and they have been subsequently strongly criticised on a number of grounds, some empirical and some theoretical. The main critiques are summarised here.

First, Marx did not anticipate the enormous growth of what we today call the 'middle class'. This group may not own the means of production but does, however, enjoy considerable economic advantages and, so far, stability. Second, Marx's stages of history have not occurred. He predicted that wages would fall and that capitalist economies would endure deteriorating economic crises that would eventually lead to the demise of capitalism. Economic crises have certainly occurred but so far capitalism is proving resilient. He predicted that the most advanced economies would experience revolution first, however communist revolutions have occurred in poor countries, in parts of Latin America and in Russia in the early 20<sup>th</sup> century. Third, it has been argued that the implementation of communism leads not to a society run to the benefit of all but to totalitarian states. The power given to leaders who were former proletarians would lead to them no longer sharing the interests of the general proletariat. The communist revolution in Russia (1917) clearly ushered in totalitarian leaders and regimes. Fourth, Marx claimed that his project was scientific. However, some claim that his 'laws' are little more than philosophical dogma. Some critiques focus on the scientific claim itself arguing that Marx, as a creature of his time, looked to science as a strong form of authority, a field of truth opposed to ideology. Many social scientists today have argued that science can be understood as another form of ideology or at least that its methods are not and can never be isolated from social and commercial forces and practices (Woolgar, 1988). Finally, Marx drew inspiration for his idea that class conflict and proletarian consciousness drove the progress of history from German philosopher Friedrich Hegel (1770-1831). Hegel had argued that 'spirit' drove history ever forward. Critics question the possibility that history can be understood as 'progress' of any kind (Foucault, 1984).

Some have suggested it is useful to attempt to differentiate the elements of Marx's ideas that are context bound from those that still have relevance and potential for development (Sperber, 2014). Sperber considers the following in the latter category: that intellectual and political movements are closely tied to the prevailing economic system at any period (Marx's base-superstructure proposition); that free and apparently voluntary market exchanges contain

within them features of domination and exploitation; that a capitalist market economy is not self-regulating but inevitably generates a series of crises.

Despite the relevance of these criticisms, aspects of Marx's work remain powerful. He anticipated the ever-intensifying 'efficiency' of capitalism, increasing globalization and the concentration of the world's capital in fewer and fewer hands. His concepts have formed the starting point for a great many highly fertile areas of inquiry and social change, for example the work of the critical theorists of the Frankfurt School (Horkheimer, 1972).

## **Nursing in the UK National Health Service**

Nursing emerged as a modern occupational group during the 19<sup>th</sup> century in the UK and the US. Today nurses make up the largest clinical group in the UK NHS (NHS Digital, 2016) and in the health systems of most industrial economies. Entry into nursing has largely moved from an apprenticeship system (see below) to a university based degree level course, a change achieved, in the UK, via a number of stages (United Kingdom Central Council for Nursing Midwifery and Health Visiting, 1986) (BBC News, 2009). Highly publicised failures of nursing care at Stafford Hospital and other UK sites from 2010 (BBC News, 2010; BBC Panorama, 2011) led to a crisis of identity for the profession and redoubled efforts from its leaders and its regulator, the Nursing and Midwifery Council (NMC) to strengthen its recruitment procedures (NMC, 2011), so-called values based recruitment being part of this effort (NHS Health Education England, 2013).

## **Autonomy and caring**

I now summarise two valued concepts within the profession, autonomy and caring.

### **Autonomy**

For nursing, as for other professional groups, autonomy is a key signifier. Definitions tend to describe the professional with autonomy as having the

authority to make decisions and the freedom to act in accordance with a professional judgement, a combination of experience and a formal knowledge base. Autonomy is vivid in the imagination of professionals, with its accentuation of authority, independence, freedom from others' meddling, clear boundaries with other occupational groups and with clients, and respect from others. In other words it is a powerful ideology. For nursing it might be considered aspirational and claims for autonomy are often repeated. The US website 'The truth about nursing dot org' which sets out to give the public clear messages about the profession, says:

Nursing is an autonomous, self-governing profession, a distinct scientific discipline with many autonomous practice features. Despite what the media may portray, nursing is not directed by physicians... nurses have a unique, holistic patient advocacy focus, a unique scope of practice, and a unique body of knowledge. (The Truth about Nursing, 2015)

This is an exemplary professional claim for autonomy.

## Caring

Many see caring as the profession's characteristic, if not unique, feature in health service delivery. If doctors cure, nurses care. Like 'autonomy', caring is positively loaded, but perhaps with a stronger moral imperative. A great deal has been written on this topic notably Benner and Wrubel's *The Primacy of Caring* (Benner & Wrubel, 1989) and other foundational texts published in the 1980s. More critical examinations, sometimes linking caring work to gender, low pay and low status, have also been published (Davies, 1998; Paley, 2002). More recently there has been a large amount of discussion about nurses *lacking* care – in the light of the highly publicised failures of care in the UK NHS mentioned above (Traynor, 2014). The Stafford events and the resulting Francis report stimulated many restatements of positions identifying nursing work and caring. Anne Bradshaw who argues for a nursing profession built on virtue ethics, claimed that:

Nightingale's principles are... echoed—unknowingly—by Francis (2013) in the recommendations that nurse training be built on trainees



selected for moral values of care and compassion...(Bradshaw, 2017 p.4)

These arguments articulate very clearly the way that the caring practices of nurses are identified or conflated with a positive personal moral quality, with gender never far away.

In summary, autonomy and caring are signifiers in nursing that are integral to its professional identity or, one might say, its professional ideology. The next section of this argument will set out to examine these concepts through a Marxist lens, though drawing on the work of many who would never describe themselves as Marxists.

## **Marxism, nursing and a sociology of the professions**

One application of Marx's ideas on class antagonism and the power of capital has taken the form of a critique of the professions, which developed from the 1970s onwards. Other notions of the professions tended to focus on their positive contribution to society and the traits that differentiate them from 'ordinary' occupations, their altruistic features, and their unique body of knowledge, however later work, notably that of Magali Larsen (Larson, 1977) foregrounded the professions as interest groups linked to the class system of capitalist societies (Freidson, 1994), groups that worked to further their own economic advantage and to maintain influence on the operation of government as well as their own social standing. Such critique has often focussed on medicine as a paradigm profession with the observation that medicine commands huge economic resources, exerts dominance over other healthcare occupations and is responsible for an increasing medicalization of society and its socially and politically induced problems (Illich, 1977), perhaps today in collaboration with the powerful pharmaceutical industry (Wazana, 2000). More recent examinations of the professions have concerned the rise of managerialism in the public sector of many advanced economies since the 1980s. This rise has appeared to threaten the independence traditionally afforded to professionals, giving rise to the provocative claim of the

'proletarianisation' of professions such as medicine (McKinlay & Arches, 1985) and nursing (Wagner, 1980) in capitalist states.

Sociologists of the professions have tended to neglect nursing, distracted by its more conspicuous neighbour (Strong, 1983). It was labelled a 'semi-profession' in one US collection in the late 1960s (Etzioni, 1969) chiefly because of its lack of social standing and political influence, not unlinked to its gendered character along with the other 'semi-professions' examined in that collection, and of a publicly acknowledged knowledge base. Witz questions whether its professional project has been effective at all (Witz, 1990).

Nevertheless the profession aspires to share in professional features and benefits: an autonomous sphere of practice, control over entry, control over a subordinate group of workers and an altruistic 'patient-centred' core to its work. The level of success of this professional project varies from country to country. In the UK sustained government intervention in the work of the profession's regulator, the Nursing and Midwifery Council, with the appointment of senior leadership from outside of the profession have been seen as evidence of very limited 'self-regulation' in nursing (Cooke, 2012; Davies & Beach, 2000). Having control over the work of paraprofessionals, in the form of support workers, has also not been entirely unproblematic for nurses. It has been seen as threatening both their close relationship with patients and their numbers as the border between their fields of work proves to be uncertain and needing constant careful restating (Allen, 2001).

Given nursing's equivocal professional status, how might we approach a Marxist analysis of nursing work and of the development of the occupation? The historical origins of modern nursing in 19<sup>th</sup> century Britain provide a good starting point.

There is not a great deal of accurate information about independent nurses in Britain in the early 19<sup>th</sup> century and before. Clearly Florence Nightingale (1820-1910) and other 'reformers' presented them unfavourably. Nightingale's challenge was to take the discredited persona and activity of these individuals and refashion them into a respectable occupation. Like many figures with a political mission it is possible that she painted an exaggerated picture of what

she was up against, writing that nursing had been left to 'those who were too old, too weak, too drunken, too dirty, too stupid or too bad to do anything else' (Gaffney, 1982 page 139). Nightingale's reforms moved nursing work from a labour done by individuals for themselves, however unsafely and in a variety of forms, to nursing as work standardised and inserted into and sold to the hospital. During the 19<sup>th</sup> century, the hospital system developed in Britain because of technical advances such as anaesthetics and antiseptic surgery as well as through the success of the medical profession itself. Many argue that the growing class of the poor in Britain, and along with it, the ill poor, was created, or at least exacerbated, by industrialisation. Hospitals developed during the 19<sup>th</sup> century as places to treat these ill poor, the casualties of capitalism, while the wealthy continued to be cared for in their own homes. This growth created a need for a worker like a nurse to staff an increasing number of hospital wards and support medical work. Nightingale's work dovetailed into this change and perhaps would not have been successful without it. The outcome was that the nurse had to sell her labour to the hospital system.

The development of the hospital system followed the same principle as industrialisation generally: the drive for the most efficient use of human labour. Florence Nightingale shared the drive for efficiency. Woodham Smith tells us:

Her requirements [for hospital design] were not merely exacting; they were revolutionary. She had a scheme for saving work by having hot water 'piped up to every floor' She wanted a... lift to bring up patients' food... [so that] 'The nurse should never be obliged to quit her floor [she wrote to Lady Canning], except for her own dinner and supper... Without a system of this kind the nurse is converted into a pair of legs... the bells of the patients should all ring in the passage outside the nurse's door... and have a valve which flies open when its bell rings and remains open in order that the nurse may see who has rung (Woodham-Smith, 1951 p. 86).

Nursing work, after a while, became subject to a further division of labour, with aids and auxiliaries and, later in the 20<sup>th</sup> century in the UK, a second level of nurse, along with the virtually free labour of students. The United States witnessed a similar, though not identical, movement. Reverby details that during the 19<sup>th</sup> century, as some aspects of unpaid family labour moved into the marketplace, and into the hospital, the assumption persisted that they would be carried out primarily for love rather than for a wage (Reverby, 1987). Newly established hospital training and hospital work set out the positions of different levels of nurse within the institution, all loyal and subordinate assistants to the physicians.

In the United States the number of schools of nursing and student nurses proliferated, not because of the need for a great number of qualified nurses but because their low or no-cost labour was highly profitable for the hospitals that hired them (Wagner, 1980). Wenger describes the working conditions of student nurses in the US during the early 20<sup>th</sup> century: '[the hospitals] provided student nurses only with room and board and a small amount of spending money in exchange for 12 to 16 hours a day of work' (p. 273). This division of the workforce set different levels of nurse against each other, the more highly paid and qualified feeling under threat from their cheaper colleagues, while those at the bottom of this hierarchy feeling put upon and undervalued. This division is typically seen as increasing efficiency while making a workforce easier to dominate.

Individual hospitals as well as the profession itself, on both sides of the Atlantic developed cults of loyalty, with their badges and uniforms, an ideology of vocation and belongingness that covered over exploitation and loss of independence. It could be that nurses began to be alienated from the products of their labour i.e. the possible satisfaction of having 'made a difference' as their work was consumed in the overall production process of the hospital system, organised and ultimately managed by administrators and doctors.

David Wagner writing about nursing in the United States claimed:

Nursing history has been characterized not by a rise in professional autonomy, responsibility, and prestige—as it is sometimes portrayed by professional leaders—but by a diminution of independence, increasing stratification and division of labor, and growing revolt against assembly-line conditions. (Wagner, 1980 p. 272).

As Wagner details, the trajectory of nursing work, from independent self-employment as private duty nurses to wage labourers working within hospitals had a different character, and timescale, to the changes seen in Britain. In 1930, he writes, between 70 and 75% of all Registered Nurses in the US were self-employed but the combined effect of the economic depression and the rise of the hospital system meant that by 1946 between only one quarter and one sixth of RNs were privately employed.

In his major work, *Capital* (Marx, 1999), Marx sets out in detail how the value of the products of labour is determined in a capitalist system. It is the capitalist's task to obtain as much value as possible from any given amount of wage labour. This efficiency will ultimately add to the surplus value, the profit, that the capitalist obtains. So in a capitalist for-profit system, the hospital owner would want to use nursing labour in the most efficient way and reduce waste, devise the most efficient shift systems, adjust the division of labour, keep wage costs as low as possible and reduce overall labour input to a level that enables proper production – the throughput of patients – to a specified standard. In a state-funded and provided system such as the UK NHS the 'profit' element is not present but all the other drives for efficiency and reduction of waste are clearly at work, particularly in times of austerity. These concerns have driven health policy since at least the introduction of general management into the UK NHS in the mid-1980s (Strong & Robinson, 1990) and continue to feature in more localised implementation of managerialist initiatives such as 'Lean' approaches (Nwankwo, Moraros, & Lemstra, 2016) all of which the nursing workforce is expected to accommodate into their working practices.

Having looked at the development of modern nursing in the UK and US and understood it in the context of the rise of industrial methods during the 19<sup>th</sup> century and an accompanying loss of autonomy, I now focus more closely on nursing work, and in particular the concept of emotional labour.

### Emotional labour and caring

Generally it is the American sociologist Arlie Hochschild who is credited with inventing the term emotional labour and inserting the concept into the vocabulary of the sociology of work. She proposed that in any social situation particular emotions come to be considered appropriate. Her seminal work, *The Managed Heart*, included examples of emotional labour in the work of flight attendants (Hochschild, 1983). While emotional labour remains a highly useful analytic concept for understanding nursing work, it perhaps applies to nurses in a more nuanced way than to many other workers.

To simplify Hochschild's analysis, the worker sells their labour and the capitalist uses it to make profit. Within this model, emotional labour describes the commodification of workers' emotions and their alienation from their own feelings in the workplace. When employers train their workers to smile at clients and show a concern for them through a range of physical gestures with the expectation that those clients will find that service pleasing and return, that is emotional labour. Emotional labour will involve both expressing a certain range of acceptable emotions and not expressing other unacceptable emotions. Acceptable emotions in most jobs would be, warmth, welcome, energy, empathy and interest in the client. Unacceptable emotions would include disinterest, disapproval, impatience and disgust. Researchers have differentiated between surface and deep acting as strategies that employees use to regulate these emotions. 'Surface acting' is considered to be the broadly conscious 'faking' of emotions that the workers know they are not feeling, while in order to do 'deep acting' workers make efforts to connect with and express some genuine emotions. In this sense, and in the context of nursing work as having roots within highly gendered family caring work, emotional labour is exploitative and alienating. The emotional displays that may (or may not as Reverby and others remind us) arise spontaneously within the family are repurposed in order to add to the profit of capitalists. In some

ways in nursing this transformation of affect is layered over with scientific rationalism for example in those aspects of professional nurse training that teach how anxiety might cause patients or carers to behave with anger toward a health professional. This knowledge can enable the nurse to shift how he or she feels and responds when confronted with such behaviour. Added to this, empathy and caring are such strong features of professional socialisation, and we could say ideology, in nursing that they provide a resource or a shared feeling rule that nurses can draw on seemingly without effort. In other words, nurses identify with the caring role required of a nurse. Despite those elements of professionalising efforts from nursing's leaders that emphasise the scientific or skills-based aspects of nursing work, individual nurses when asked about motivations continue to strongly identify their paid labour with family based caring (Traynor & Buus, 2016).

Some accounts of emotional labour in nursing leave out the part played by capital—or rather by a management that sees it as part of its role to 'manage' the emotional displays of its workers for its own benefit. Leaving out this essential feature of emotional labour as conceived by Hochschild reduces the term to the less politically engaged observation that nursing work is emotionally demanding because nurses experience emotions that they do not express with patients and sometimes co-workers.

However, attempts to manage the emotion work of nurses are increasing. First there have been attempts to require employers and universities to implement 'values-based recruitment' with the intention of selecting, as employees or student nurses, only those who reveal themselves to be compassionate and non-judgemental as a result of formal recruitment practices (McPherson & Hiskey, 2016). Second, there has been an increasing number of UK policies and initiatives seeking to ensure that nurses display appropriate behaviours, for example the Care in Practice project (Commissioning Board Chief Nursing Officer and Department of Health Chief Nursing Adviser, 2012). Finally there is scrutiny of nurses' behaviour from government agencies and independent regulators for example in the form of the Care Quality Commission's scheduled and unscheduled site visits where,

according to its own publicity, they ask patients whether they have been treated with care and understanding by staff (Care Quality Commission, 2018).

We might consider these, at least in part, as managerial and governmental attempts to shape the display rules that nurses are expected to pay attention to, based on the assumption that lack of emotional sensitivity on the part of nurses is at least partly responsible for failures in care (Fletcher, 2000).

However there is another, deeper set of display rules at work. As mentioned before, the profession has a much longer identification with altruistic and caring values than the UK NHS's recent re-emphasis on these values after the events at Stafford and elsewhere (BBC News, 2010; Chief Nursing Officer for England and National Quality Board, 2014; Ford & Stephenson, 2011). In fact it has been argued that it is this deep identification with caring that makes working in today's NHS so alienating an experience for many clinicians (Maben, Latter, & Clark, 2007). Nurses and care workers have been encouraged by employers to naturalise emotional labour (Johnson, 2015).

One of the hazards of identifying with a caring role is that of undervaluing one's own work with the belief that 'what I do is natural, I don't have to try' (Johnson, 2015 p. 117) and opening oneself to the possibility of exploitation.

However, many nurses feel that it is managerial processes, concern with financial matters, shortage of staff and lack of time that thwarts their desire to be caring (Traynor, 1996). Nurses appear to be ambivalent about initiatives such as the six C's promoted by the Chief Nurse for England (Commissioning Board Chief Nursing Officer and Department of Health Chief Nursing Adviser, 2012) and the Care in Practice project mentioned above (O'Driscoll, Allan, Liu, Corbett, & Serrant, 2018). On the one hand they support something that restates their own values. On the other they see health service reorganisations, along with attempts to contain costs and set performance targets as preventing them from acting out those values to their own satisfaction. This is another aspect of emotional labour in nursing—deep ambiguity about the display rules at work. One set of rules requires caring and compassion while another in effect says 'act like you have care and compassion but above all keep up with the pace of work'.



## Discussion

Motivated by the critique made possible by Marx, one of Ricoeur's 'masters of suspicion', I have explored how certain of his concepts can be mobilised to re-examine nursing work. I have focussed this critique on two key values for the profession, autonomy and caring.

What might be the usefulness of such a re-examination? Society's comfortable beliefs about itself represented an outrage or at least an obstacle for Marx and his fellow suspects, an obstacle to the possibility of gaining genuine self-knowledge. Each of the three had their own way of understanding the life of illusion that they believed characterised European culture across the 19<sup>th</sup> and into the first decades of the 20<sup>th</sup> centuries. For Marx the notion of ideology played a key part in his theory of class antagonism. Ideology was one of the methods by which the owners of the means of production maintained the stability of their power over the proletariat. Since his original writing, the use of the concept of ideology has been taken into a broader range of critical projects. Foucault's development of the notions of discourse, discursive practice and of the episteme owe a debt to the idea of ideology in the sense of the unconcealing of the constructed character of apparently natural categories and understandings. Along with that revelation comes an analysis of the operation of power in society. For Foucault power is not simply the oppression of one group by another but a two-way process where the categories, or rather the practices of category-making developed by particular institutions, such as those of medicine, make certain spaces and identities possible for a range of human subjects.

For Marx the opposite and antidote to ideology was science. Like Freud he saw his work as fundamentally scientific. Later thinkers, including Foucault, did not have such an optimistic view either of science or of any notion of the progress of history, vivid in the imagination of Marx through the work of Hegel, whose ideas he drew upon. For Foucault, discourses, in the sense of organised, though possibly unconscious, systems of understanding, categorising and speaking about the world are unavoidable. From this

apparently highly relativistic position there is nowhere to stand outside of discourse from which to make neutral, unlocated and uninterested judgements. This makes decisions about discursive matters and their ethical effects complex and the source of a life-long investigation for Foucault culminating in a return to classical ideas of the self and its development (Foucault, 1986).

Despite this refusal to claim the firm ground of scientific knowledge, the project of unconcealing remains an ethical and an urgently required project for those who work in the tradition of the masters of suspicion. As previously mentioned, Marx's overriding intention was to bring about change, not merely to describe. The unconcealing of the operation of ideology can persuasively be seen as a first step toward change for an individual, a group and, in broader terms for society as a whole. The usefulness, or otherwise, of this paper rests on this claim. The arguments made by historians and sociologists summarised in this paper present, I believe, a convincing case that nurses have and continue to be, exploited by powerful ideologies that identify the work of nurses with domestic gender roles. To put it bluntly, nursing work can be seen as one example of the oppression of women, because the nursing workforce is predominantly female, by capitalist patriarchy. The highly prized notion of professional autonomy has, in nursing's history, become entwined with an ideology of the primacy of caring. An uncritical belief in both can mask the details of the operation of power that works to constrain the thinking, work and working conditions of nurses. These two key values may appear to be distinct, even as counterbalances to one another, as Reverby (1987) documented, at least in terms of the gendered notion of professional work critiqued by Davies (1995) but they operate together in an oppressive way. We believe we are autonomous but our work is heavily circumscribed by others—managers, managerial systems and efficiency targets, other powerful professions and regulated by those outside the profession. We believe that nursing allows an expression of a natural caring character but the industrial model which is always threatening the creation of a humane healthcare environment constantly thwarts satisfaction of that desire. Nurses know full well that their work often leads to frustration and loss of early ideals (Maben et

al., 2007) but, Marx might argue, without an escape from the ideologies of professional autonomy and of the essential value of caring and caring work, nurses' understanding remains fogged to the real causes of this frustration. Without this awareness and critique, the enjoyment of a generalised sense of martyrdom remains attractive but ultimately unproductive (Evans, Pereira, & Parker, 2008; Traynor & Evans, 2014). This I believe is the potential usefulness of the critique presented in this paper and of this special issue dedicated to investigating the broad, though urgent, field of 'nursing and politics'.

Finally, without an acknowledgement of the difference and variation in all matters to do with nursing work, the above analysis and discussion are little more than gestures. I want to end by mentioning exceptions and nuances regarding nursing work and the ideological effects of autonomy and caring. While it can certainly be argued that caring work continues to be poorly valued and rewarded in many Western societies, nursing and nurse education has become a site for increasing inclusivity and the representation of women in universities and, to some extent, in professional high-level decision-making. Alongside the recent nostalgic restatement of caring and empathetic values referred to above as part of a response to 'failures' of care, nursing's leaders in the UK, US and other industrialised nations have emphasised the skills base of nursing work and its positive contribution to public health (see for example WHO's 'Nursing Now' campaign (World Health Organization, 2018)). Nurses themselves have initiated challenges to government policy that they believe are harmful to the profession (Gill, 2016). Nurses continue to maintain agency in the face of considerable structural oppression

## Conclusion

Marx's theories of the role of capital, ideology and of class antagonism can be used to re-examine two powerful concepts for nursing—autonomy and caring. These comfortable certainties can be seen to mask the operation of forms of exploitation of nurses. Raising awareness of this alternative way of understanding nursing work can become a first step toward change.



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